DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 05-002

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2005

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $ 7,139,000.00
b. FFY 2006 $15,729,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, Pages 2a, 6a, 13, 14, 16a, 17, 20, 22, 23 and 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Pages 2a, 6a, 13, 14, 16a, 17, 20, 22, 23 and 24

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Payment Systems

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review and approval authority has been delegated to the Department of Public Welfare

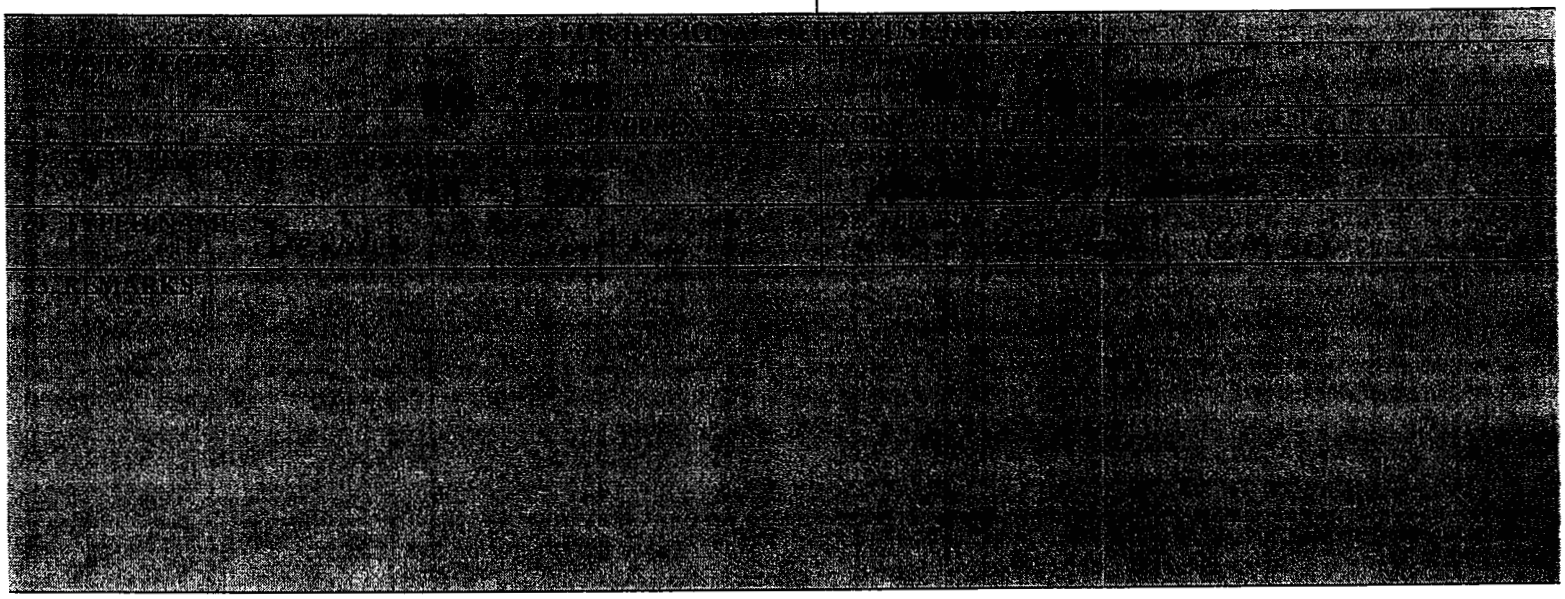
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Estelle B. Richman

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED:

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, Pennsylvania 17105



Payments for Direct Medical Education Costs

(a) The Department reimburses eligible hospitals the Medical Assistance inpatient costs for direct medical education, that are determined allowable under Medicare cost principles in effect as of June 30, 1985.

(b) Payments

(1) For the period July 1, 1997 through December 31, 1997, eligible providers shall receive monthly payments equal to their monthly payments for the period January 1, 1997 through June 30, 1997.

(2) For the period January 1, 1998 through December 31, 1998, eligible providers shall receive quarterly payments based on the monthly payments set forth in (b)(1) converted to quarterly payments.

(3) For the period January 1, 1999 through December 31, 1999, eligible providers shall receive quarterly payments as set forth in (b)(2).

(4) For the period January 1, 2000 through June 30, 2000, payments set forth in (b)(3) will be increased by 4 percent.

(5) For State Fiscal Year 2000-2001, eligible providers will receive quarterly payments which equal the aggregate amount paid for the period July 1, 1999 through June 30, 2000, increased by 2.4 percent and divided into four payments.

(6) For the period July 1, 2001, through December 31, 2001, eligible providers will receive two quarterly payments which equal the amount paid quarterly for the period July 1, 2000, through June 30, 2001.

(7) For the period January 1, 2002, through June 30, 2002, eligible providers will receive two quarterly payments, each of which equals the quarterly payment amount as of December 31, 2001, inflated by 7.231 percent.

(8) For the period July 1, 2002, through December 31, 2002, eligible providers will receive two quarterly payments, each of which equals the quarterly payment amount as of June 30, 2001, inflated by 3.1 percent, then inflated by 1.0 percent and then inflated by 3.1 percent.

(9) For the period January 1, 2003, through December 31, 2004, eligible providers will receive quarterly payments, each of which equals the quarterly payment amount as of December 31, 2002, inflated by 1.0 percent.

(10) For the period January 1, 2005, through June 30, 2005, eligible providers will receive two quarterly payments, each of which equals the quarterly payment amount as of December 31, 2004, inflated by 3.0 percent.

(c) Direct medical education payments shall be adjusted as necessary in accordance with the limitations set forth in Part V.

(d) Direct medical education payments shall be considered final and prospective and are not subject to cost settlement.

(9) For the period January 1, 1996 to December 31, 1996, each hospital's case mix adjusted cost per case value in (g)(8) is the amount as of December 31, 1995, decreased by 5 percent to account for forecast error.

(10) For the period January 1, 1997 to December 31, 1997, each hospital's case mix adjusted cost per case value in (g)(9) is increased by 2 percent.

(11) For the period January 1, 1998 through December 31, 1998, each hospital's case mix adjusted cost per case value in (g)(10) is increased by 2.7 percent.

(12) For the period January 1, 1999 through December 31, 1999, each hospital's adjusted cost per case value (g)(11) is increased by 2 percent.

(13) For the period January 1, 2000 through December 31, 2000, each hospital's case mix adjusted cost per case value in (g)(12) is increased by 2.8 percent.

(14) Effective January 1, 2001, each hospital's case mix adjusted cost per case value in (g)(13) is increased by 3 percent.

(15) Effective January 1, 2002, each hospital's case mix adjusted cost per case value in (g)(14) is increased by 4 percent.

(16) Effective July 1, 2002, each hospital's case mix adjusted cost per case value in (g)(15) is increased by 1 percent.

(17) Effective January 1, 2003, each hospital's case mix adjusted cost per case value in (g)(16) is increased by 3.1 percent.

(18) Effective July 1, 2003, each hospital's case mix adjusted cost per case value in (g)(17) is increased by 1 percent.

(19) Effective January 1, 2005, each hospital's case mix adjusted cost per case value in (g)(18) is increased by 2.5 percent.

(h) The amount determined under (g)(15) is limited to $7,237.70 for the period January 1, 2002 through June 30, 2002. The amount determined under (g)(16) is limited to $7,310.08 for the period July 1, 2002 through December 31, 2002. The amount determined under (g)(17) is limited to $7,536.69 for the period January 1, 2003, through June 30, 2003. The amount determined under (g)(18) is limited to $7,612.06 for the period July 1, 2003, through December 31, 2004. The amount determined under (g)(19) is limited to $7,802.36 for the period January 1, 2005 through June 30, 2005.

PROSPECTIVE REHABILITATION PAYMENT SYSTEM

Rehabilitation Hospitals, Distinct Part Drug and Alcohol Detoxification-Rehabilitation Units of General Hospitals and Distinct Part Medical Rehabilitation Units of General Hospitals

General Policy

The Department pays for inpatient rehabilitation services under a prospective payment system. Payment is made on a per diem basis. The prospective per diem rate for each provider is established using that provider's base year per diem costs trended forward by inflation factors.

All compensable services provided to an inpatient are covered by the prospective per diem rate except for direct care services provided by salaried practitioners who must bill the Medical Assistance Program directly.

Costs are determined using Medicare principles unless otherwise specified. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general cost center and allocated according to established accounting procedures.

Payment Limits

The Department's payment for inpatient services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

The Department limits the prospective per diem to rehabilitation providers for the period January 1, 2002, through June 30, 2002, to $1101.18. For the period July 1, 2002, through December 31, 2002, the Department limits the prospective per diem to $1,112.19. For the period January 1, 2003, through June 30, 2003, the Department limits the prospective per diem to $1,146.67. For the period July 1, 2003, through December 31, 2004, the Department limits the prospective per diem to $1,158.14. For the period January 1, 2005, through June 30, 2005, the Department limits the prospective per diem to $1,187.10.

Calculation of Prospective Per Diem Rate

The prospective per diem rate of each rehabilitation provider will be determined as follows:

(a) For a provider enrolled in the Medical Assistance (MA) Program, as of December 31, 2001, its prospective base per diem rate will be its per diem rate as of December 31, 2001.

(b) The base per diem rate as of December 31, 2001, will be inflated by the following inflation factors.

(1) Effective January 1, 2002, the December 31, 2001, base per diem rate will be increased by 4 percent.
(2) Effective July 1, 2002, the amount determined under (1) will be increased by 1 percent.
(3) Effective January 1, 2003, the amount determined under (2) will be increased by 3.1 percent.
(4) Effective July 1, 2003, the amount determined under (3) will be increased by 1 percent.
(5) Effective January 1, 2005, the amount determined under (4) will be increased by 2.5 percent.

(c) For an inpatient rehabilitation provider whose first full fiscal year of operation under the Medical Assistance Program is subsequent to December 31, 2001, the first full fiscal year of operation under the Medical Assistance Program will serve as its base year. The Department will pay full allowable Medical Assistance costs in the base year. Payment for subsequent years will be the audited per diem cost trended forward from the base year, increased by applicable inflation factors.

Limits to Payments

The Department's payment for inpatient hospital services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate, the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

(3) Be an acute care general hospital, or distinct part rehabilitation or psychiatric unit thereof, defined by Medicare as a rural hospital or sole community hospital and be at or above the 75th percentile in the ratio of Medical Assistance acute care cases to total acute care cases in a ranking of all in-state hospitals;

(4) Be an acute care general hospital, that has rendered a total number of Medical Assistance inpatient days (including fee-for-service, managed care, administrative and out-of-state days and including days from units) greater than two standard deviations above the mean of the total number of Medical assistance days rendered by all acute care general hospitals. Hospitals qualifying under this condition will be ranked with all other previously qualified hospitals to determine a payment amount.

(b) To qualify as a disproportionate share hospital, the hospital must meet at least one of the following conditions:

(1) Be identified as a children's hospital;

(2) Have at least two physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to such services under Medical Assistance Program; or

(3) Be identified as a hospital that did not offer nonemergency obstetric services to the general population on or after December 21, 1987.

Part II. Disproportionate Share Payments to Acute Care General Hospitals

(a) Acute care hospitals that meet the conditions in Part I (a)(1), (a)(2) or (a)(4), are assigned a disproportionate share percentage ranging from 1 percent to 15 percent. Qualifying hospitals are ranked from high to low based on their ratio of total Title XIX days to total days. The qualifying hospital with the highest ratio of Title XIX days to total days is assigned a disproportionate share percentage of 15 percent. For each other hospital qualifying under this section, the disproportionate share percentage is:

(1) 1 percent, plus -

(2) 13 percent multiplied by a fraction: the numerator of which is the ratio of Title XIX days to total days of the qualifying hospital minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals; and the denominator of which is the ratio of Title XIX days to total days of the second to highest hospital on the list of all such qualifying hospitals, minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals.

(b) Acute care hospitals that meet the conditions in Part I (a)(3) receive a rural disproportionate share percentage ranging from 1 percent to 10 percent. Qualifying hospitals are ranked from high to low based on their ratio of Title XIX days to total days. The qualifying hospital with the highest ration of Title XIX days to total days is assigned a disproportionate share percentage of 10 percent. For each other hospital qualifying under this section, the disproportionate share percentage is:

(1) 1 percent, plus -

(2) 8 percent multiplied by a fraction: the numerator of which is the ratio of Title XIX days to total days of the qualifying hospital minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals; and the denominator of which is the ratio of Title XIX days to total days of the second to highest hospital on the list of all such qualifying hospitals, minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals.

(c) Hospitals that qualify under both the section (a) and section (b) will receive the higher of percentages, but will not receive both percentages.

(d) The Department prospectively calculates the annual disproportionate share payment amount for qualifying acute care general hospitals by multiplying the disproportionate share percentage determined under sections (a) - (c) by the hospital's projected Title XIX and general assistance income for acute care cases during the fiscal year.

(e) Annual payments are divided into four quarterly installments.

Part V. Aggregate Limits to Inpatient Disproportionate Share, Outpatient Disproportionate Share and Direct Medical Education

For the period July 1, 1998 through June 30, 1999, the Department shall distribute to providers that are eligible for direct medical education payments and/or disproportionate share payments including outpatient disproportionate share, the aggregate annualized amount of $175 million.

For the period July 1, 1999 through December 31, 1999, the Department shall distribute to providers that are eligible for direct medical education payments and/or disproportionate share payments, including outpatient disproportionate share, the aggregate amount of $87.5 million.

For the period January 1, 2000 through June 30, 2000, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate amount of $91 million.

For the period July 1, 2000 through June 30, 2001, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate annualized amount of $182.784 million.

For the period July 1, 2001 through December 31, 2001, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate amount of $91.392 million.

For the period January 1, 2002, through June 30, 2002, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate amount of $98.000 million.

For the period July 1, 2002, through June 30, 2003, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate annualized amount of $197.217 million.

For the period July 1, 2003 through June 30, 2004, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate annualized amounts of $ 194.818 million.

For the period July 1, 2004 through June 30, 2005, the Department shall distribute to providers that are eligible for direct medical education and/or disproportionate share payments, including outpatient disproportionate share, the aggregate annualized amounts of $ 204.709 million.

Outpatient Disproportionate Share

The Department will make quarterly outpatient disproportionate share payments to those hospitals that meet the inpatient disproportionate share eligibility criteria as of July 1, 1994, and which continue to be eligible for outpatient disproportionate share payments. The Department determines each eligible hospital's percentage of the Department's expenditures made to all eligible outpatient disproportionate share hospitals for outpatient services. The Department calculates each eligible hospital's outpatient disproportionate share payment by applying this percentage to the total amount of funds available for purposes of making outpatient disproportionate share payments, subject to the limitations set forth in Attachment 4.19A, Part V.

PROSPECTIVE PSYCHIATRIC PAYMENT SYSTEM

Private Psychiatric Hospitals and Distinct Part Psychiatric Units of Acute Care General Hospitals

General Policy

The Department pays for inpatient psychiatric services under a prospective payment system. Payment is made on a per diem basis. The prospective per diem rate for each provider is established using that provider's base year per diem costs trended forward by inflation factors.

All compensable services provided to an inpatient are covered by the prospective per diem rate except for direct care services provided by salaried practitioners who bill the Medical Assistance Program directly.

Costs are determined using Medicare principles unless otherwise specified. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general cost center and allocated according to established accounting procedures.

Payment Limits

The Department's payment for inpatient services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

The Department limits the prospective per diem to psychiatric providers for the period January 1, 2002, through June 30, 2002, to $1101.18. For the period July 1, 2002, through December 31, 2002, the Department limits the prospective per diem to $1,112.19. For the period January 1, 2003, through June 30, 2003, the Department limits the prospective per diem to $1,146.67. For the period July 1, 2003, through December 31, 2004, the Department limits the prospective per diem to $1,158.14. For the period January 1, 2005, through June 30, 2005, the Department limits the prospective per diem to $1,187.10.

Nonallowable Capital Costs

Capital costs for new or additional inpatient psychiatric beds are not allowable under the Medical Assistance Program unless a Section 1122 approval letter, a Certificate of Need, or a letter of nonreviewability had been issued for the additional beds by the Department of Health prior to July 1, 1991.

Capital costs related to replacement beds are not allowable unless the facility received a Certificate of Need or letter of nonreviewability for the replacement beds. To be allowable, the replacement beds must physically replace beds in the same facility and the capital costs related to the beds being replaced must have been recognized as allowable.

In addition to the above criteria, to receive payment for capital costs related to new, additional or replacement beds, the project must have been substantially implemented within the effective period of the original Section 1122 approval or the original Certificate of Need, including one six-month extension.

Calculation of Prospective Per Diem Rate

The prospective per diem rate of each private psychiatric hospital and distinct part psychiatric unit of an acute care general hospital will be determined as follows:

(a) The hospital or unit's reported Medical Assistance allowable inpatient costs from its Fiscal Year 1989-90 Cost Report (MA-336) are divided by its reported Medical Assistance inpatient psychiatric days.

(b) The amount determined under (a) is reduced by a 1.69 percent overreporting factor.

(c) The per diem cost determined in (b) will be inflated to the year for which the rate is being set using the following inflation factors:

(1) 5.3 percent to account for Fiscal Year 1990-91 inflation.

(2) 5.2 percent to account for Fiscal Year 1991-92 inflation.

(3) 4.6 percent to account for Fiscal Year 1992-93 inflation.

(4) 4.3 percent to account for Fiscal Year 1993-94 inflation. This inflation factor is applied effective July 1, 1993, for all inpatient psychiatric facilities which qualified for a disproportionate share rate enhancement in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other inpatient facilities.

(5) Effective January 1, 1995, the amount determined under (c)(4) will be increased by 3.7 percent.

(6) Effective January 1, 1996, the amount determined under (c)(5) will be multiplied by .95.

(7) Effective January 1, 1997, the amount determined under (c)(6) will be increased by 2 percent.

(8) Effective January 1, 1998, the amount determined under (c)(7) will be increased by 2.7 percent.

(9) Effective January 1, 1999, the amount determined under (c)(8) will be increased by 2 percent.

(10) Effective January 1, 2000, the amount determined under (c)(9) will be increased by 2.8 percent.

(11) Effective January 1, 2001, the amount determined under (c)(10) will be increased by 3 percent.

(12) Effective January 1, 2002, the amount determined under (c)(11) will be increased by 4 percent.

(13) Effective July 1, 2002, the amount determined under (c)(12) will be increased by 1 percent.

(14) Effective January 1, 2003, the amount determined under (c)(13) will be increased by 3.1 percent.

(15) Effective July 1, 2003, the amount determined under (c)(14) will be increased by 1 percent.

(16) Effective January 1, 2005, the amount determined under (c)(15) will be increased by 2.5 percent.

(d) For an inpatient psychiatric provider whose first full fiscal year of operation under the Medical Assistance Program is subsequent to Fiscal Year 1989-90, the first full fiscal year of operation under the Medical Assistance Program will serve as its base year. The Department will pay full allowable Medical Assistance costs in the base year. Payment for subsequent years will be the audited per diem cost trended forward from the base year using the inflation factors described under (c).

(e) For the period January 1, 2001, through December 31, 2001, the Department limits the prospective per diem rate to $1,058.83. For the period January 1, 2002, through June 30, 2002, the Department limits the prospective per diem rate to $1,101.18. For the period July 1, 2002, through December 31, 2002, the Department limits the prospective per diem to $1,112.19. For the period January 1, 2003, through June 30, 2003, the Department limits the prospective per diem to $1,146.67. For the period July 1, 2003, through December 31, 2004, the Department limits the prospective per diem to $1,158.14. For the period January 1, 2005, through June 30, 2005, the Department limits the prospective per diem to $1,187.10.

Exclusions From the Prospective Psychiatric Payment System

(a) Inpatient psychiatric facilities which place a new capital project into service after the base year are entitled to payment for certain capital costs, provided the qualifying criteria are met:

(1) The costs related to the capital project must represent increases in the inpatient psychiatric facility's allowable depreciation and interest costs for a fixed asset that was entered in the inpatient psychiatric facility's fixed asset ledger in the year being audited.

(2) The costs must be attributable to a fixed asset that is:

(i) approved for Certificate of Need on or before June 30, 1991, in accordance with 28 Pa. Code Chapter 301 (Relating to limitations on Federal participation for capital expenditures) or 28 Pa. Code Chapter 401 (Relating to Certificate of Need program), or not subject to review for Certificate of Need as evidenced by a letter of nonreviewability dated on or before June 30, 1991; and

(ii) related to patient care in accordance with Medicare standards.

(b) In order for an inpatient psychiatric facility to qualify for an additional capital payment set forth in this section, the following criteria must also be met:

(1) The inpatient psychiatric facility's rate of increase in overall audited costs must exceed 15 percent.

(2) The inpatient psychiatric facility's rate of increase for allowable depreciation and interest must exceed its rate of increase for net operating costs.

(c) Effective July 1, 1993, for each inpatient psychiatric facility which requests an additional capital payment, the Department will audit its Medical Assistance cost reports for the fiscal year for which the request is made, the prior fiscal year and all subsequent fiscal years for which additional capital payment is requested. To the extent that the facility is determined eligible to receive an additional capital payment under this section, the following applies: